Revision Dates: 10/1/2018; 12/08/2011

General Information

All claims submitted to AHCCCS are extensively edited by the AHCCCS claims processing system.

The editing process begins when the system checks the claim form to ensure that all required fields have been filled in and that no completed fields are filled out incorrectly. Incorrectly filled out fields include, but are not limited to, the following:

- The use of letters instead of numbers when numbers are required (and vice versa); and/or
- Not entering a valid 9-digit AHCCCS ID, beginning with an A; and/or
- Not including the entire required data set, such as when a provider uses 6 digits for an NPI instead of 10; and/or
- Invalid diagnosis code.

If the **required fields** are not completed or if *any* fields are completed incorrectly, an error code will be assigned to the claim.

- For example, if the date "December 10, 2003" should be recorded as 12/10/2003 (MM/DD/YYYY format) and the claim is received with 2003/12/10, the edit will create a failure for an invalid date.

The system also confirms that a provider ID, an ordering provider ID (for CMS 1500 forms), a member ID, date(s) of service, a place of service code (for CMS 1500 forms), diagnosis code(s), procedure/revenue/NDC code(s), and billed charges are present on the claim.

After editing for completeness and correctness of the data submitted, the system edits to ensure that the data fields are valid and logical. The most important of these edits ensures that:

- The provider ID number is a valid AHCCCS registered provider on the date of service delivery;
- The provider has the authority to provide and bill for this service;
- The member is on file, eligible, and entitled to the service;
- The service was covered by AHCCCS on the date it was delivered; and
- Diagnosis and procedure codes were valid for the date of service.

Another set of edits ensures that the claim complies with AHCCCS policy requirements. These include:

- Prior authorization is obtained if required;
- The claim is reviewed by AHCCCS medical staff before payment, if required; and
- The service is allowed for the member's age and gender.

. The claims processing system reviews the claim for any service limitations, duplicates, and checks whether the member, provider, date of service, and procedure/diagnosis on the claim are the same as on a previously paid claim.

Editing Process

The claims system attempts to apply all edits during a single processing cycle. However, if certain data fields are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.

When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits. However, if a crucial edit is encountered (such as a **required** field being found blank) the editing process for the rest of the claim will be **stopped**. The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit. This includes, but is not limited to, missing, incorrect or invalid data.

> Note: If there are other fields that are blank, filled out incorrectly, or invalid appearing *after* the field that failed the initial editing process, these will not be caught by the system until *after* the provider makes the initial field correction and sends the **replacement** claim back in for review.

Once the edit has been corrected and resubmitted by the provider the editing process may continue and may encounter other critical edits. This may cause the claim to deny and be reported on the remit.

For additional information on how to submit a replacement claim, please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual. For additional information on the remit, refer to Chapter 27, Understanding the Remittance Advice of the Fee-For-Service Provider Billing Manual.

Examples of edit codes:

- H001.1 - Service Provider ID - Field Is Missing
- H001.3 - Service Provider ID - Field Is Not On File
- L023.1 -Diagnosis Code #1 – Invalid for Recipient Age & Gender
- L023.2 -Diagnosis Code #1 – Invalid for Recipient Age
- L023.3 -Diagnosis Code #1 – Invalid for Recipient Gender

If one or more edits fail during the editing process, there are two possible outcomes:

1. The claim may stop processing and "pend" for internal review when the error detected concerns data or procedures that may be resolved by AHCCCS staff.

- When a claim requires Medical Review t will pend internally until Medical Review screens the services being billed.

- Internally pended claims are generally handled without input from the provider. The exception is when medical documentation is requested for a claim under review

2. The claim may be denied. Please see the Fee-For-Service Provider Billing Manual, Chapter 26, Correcting Claim Errors for further information.

    - If the data required for adjudication is complete, but the service does not meet AHCCCS policy requirements, the claim will deny without payment.

      For example, if a provider was not registered or if a member was not eligible on the date of service, the claim will deny.

AHCCCS' intention is to process all clean claims in a timely manner, normally within 30 days. A claim is considered "clean" on the date the following conditions are met:

- All required information has been received by AHCCCS, *and*
- The claim meets all AHCCCS submission requirements, *and*
- The claim is legible enough to permit electronic image scanning, *and*
- Any errors in the data provided have been corrected, *and*
- All medical documentation required for medical review has been provided.

A ***Claim Reference Number (CRN)*** is assigned to all claims when they are initially submitted to AHCCCS. The first five characters of the CRN represent the Julian date that the claim was initially received on by AHCCCS. The remaining numbers make up the claim document number that is assigned by AHCCCS.

When submitting documentation (e.g., Medicare EOB) following the initial submission of a claim, the CRN assigned when the claim was first submitted should be provided. This is required so that AHCCCS is able to link the new documentation to the claim.

> Note: Please see the References Section for information on the 275 Transaction Insight Portal and how to upload attachments. Itemized statements from hospitals, AHCCCS Daily Trip Reports, and additional documentation may be submitted through this portal.

Providers also must provide the initial CRN when replacing (resubmitting/adjusting) or voiding a claim. If a claim is resubmitted without the CRN, the claim will be treated as a first-time submission and may not pass the 6- month initial claim filing deadline or the 12-month clean

claim filing deadline. If the initial CRN is not provided, the claim also may be denied as a duplicate of an existing claim.

Pricing of Claims

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment.

The AHCCCS claims processing system prices claims using the following pricing hierarchy:

1. AHCCCS reimburses the Medicare coinsurance and deductible, minus any other third party payments, for Medicare-covered services for members with Medicare.
2. If the provider has negotiated a settlement with the AHCCCS Office of Administrative Legal Services the claim is priced in accordance with the negotiated settlement.
3. If there is a provider-specific rate on file for the service, covered charges are priced at 100 percent of billed charges or the provider-specific rate, whichever is less, except when acute general hospital inpatient pricing methodology is used.
4. If there is no provider-specific rate for the service, the system determines if there is a capped fee on file for the procedure.

   If there is a capped fee for the service, covered charges are priced at 100 percent of the billed charges or the capped fee for service, whichever is less

   AHCCCS had adopted a facility/non-facility rate differential similar to the Medicare format. The facility/non-facility rate structure assigns a reimbursement rate for a given AHCCCS-covered procedure code based on the billed place of service (POS) code.

   The following POS codes are defined as a facility for purposes of the facility/non-facility rate structure:

19	21	22	23	24	26	31	34
41	42	51	52	53	56	61	

5. The system determines if a specific rate has been prior authorized.

   If there is a prior authorized rate on file for the provider, member, date of service, and service being billed, the claim is priced at 100 percent of covered billed charges or the prior authorized amount, whichever is less.

6. If none of the above pricing methodologies have been applied at this point, the claim may be reimbursed at either 58.66 per cent of covered billed charges or for outpatient hospital or ambulatory surgical centers at the covered bill charges times the cost-to-charge ratio. .

Once a claim is priced, applicable discounts, penalties, insurance payments, etc. are applied to the allowed amount to arrive at a final reimbursement amount.

References

For additional information on submitting documentation via the Transaction Insight Portal please visit the Provider Training webpage at:

https://www.azahcccs.gov/Resources/DFSMTraining/index.html

Or the Transaction Insight Portal Web Upload Attachment Guide at:

https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2018/TransactionInsight_TI_PortalWebUploadAttachmentGuide.pdf

Revisions/Update History

Date	Description of Change(s)	Page(s)
10/1/2018	Clarifications added to General Information section, including additional information being added to the editing process and what the system looks for: *"The editing process begins when the system checks the claim form to ensure that all required fields have been filled in and that no completed fields are filled out incorrectly. Incorrectly filled out fields include, but are not limited to, the following:* • *The use of letters instead of numbers when numbers are required (and vice versa); and/or* • *Not entering a valid 9-digit AHCCCS ID, beginning with an A; and/or*	1-2

	• *Not including the entire required data set, such as when a provider uses 6 digits for an NPI instead of 10; and/or* • *Invalid diagnosis code."* Editing Process extensively updated. New verbiage added includes: *"The system attempts to apply all edits during a single processing cycle. However, if certain data fields are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.* *When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits. However, if a crucial edit is encountered (such as a* ***required*** *field being found blank) the editing process for the rest of the claim will be* ***stopped****. The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit. This includes, but is not limited to, missing, incorrect or invalid data. Note: If there are other fields that are blank, filled out incorrectly, or invalid appearing after the field that*	2-3

	failed the initial editing process, these will not be caught by the system until after the provider makes the initial field correction and sends the ***replacement*** *claim back in for review.* *Once the edit has been corrected and resubmitted by the provider the editing process may continue and may encounter other critical edits. This may cause the claim to deny and be reported on the remit."* Claim Reference Number (CRN) section updated. Clarification added to AHCCCS Claims Processing Hierarchy and Pricing Claims sections. References Section Added "Recipient" changed to "member" throughout. References section added	 3 4 5 All that are not system edit definitions. 5